SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Filing at a Glance

Company: Time Insurance Company

Product Name: Time Insurance-Base Chassis	SERFF Tr Num: ASWX-126478651	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 44723
Sub-TOI: H16G.001C Any Size Group - Other	Co Tr Num: IHAR01145FIF01	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: SPI AssurantHealthandEmployeeBenef	Disposition Date: 02/17/2010
	Date Submitted: 01/28/2010	Disposition Status: Approved-Closed
Implementation Date Requested: 03/01/2010		Implementation Date:

State Filing Description:

General Information

Project Name: Time Insurance-Base Chassis	Status of Filing in Domicile:
Project Number: IH AR01145FIF01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 02/17/2010	Explanation for Other Group Market Type:
	State Status Changed: 02/17/2010
Deemer Date:	Created By: SPI AssurantHealthandEmployeeBenef
Submitted By: SPI AssurantHealthandEmployeeBenef	Corresponding Filing Tracking Number:

Filing Description:

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)

Enrollment Form for Medical Insurance for Individuals and Families: 29300 (Rev. 1/2010)

Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and Families: 29400 (Rev. 1/2010)

Tele-App Part 2 Enrollment Form for Medical Insurance for Individuals and Families: 29500 (Rev. 1/2010)

Preferred Rating Questionnaire: 26566

Amendment of Enrollment form: 30216

Dear Sir or Madam:

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

The above-referenced forms are submitted for your review and approval: Enrollment Form for Medical Insurance for Individuals and Families, 29300 (Rev. 1/2010), 29400 (Rev. 1/2010) and 29500 (Rev. 1/2010).

Form number 29300 is completed when an applicant is applying for coverage through the paper application process. The form series 29400 and 29500 are completed when an applicant is applying for coverage through the telephone application process, an online process or software based process.

Also enclosed are a Preferred Rating Questionnaire and an Amendment to the enrollment form. The amendment is used when the consumer wants to amend their response to a question on a previously completed application.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Upon approval, the amended forms will be used to market major medical insurance to individuals by independent agents licensed in your state.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Christine R. Fleming
Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Company and Contact

Filing Contact Information

Christine Fleming, Senior Contract Compliance Analyst
501 W. Michigan St.
Milwaukee, WI 53203

christine.fleming@assurant.com
414-299-1306 [Phone] 1306 [Ext]
414-299-6168 [FAX]

Filing Company Information

Time Insurance Company
501 W. Michigan St.
Milwaukee, WI 53203
(800) 800-1212 ext. [Phone]

CoCode: 69477
Group Code: 19
Group Name:
FEIN Number: 39-0658730

State of Domicile: Wisconsin
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	$50.00	01/28/2010	33862874

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/17/2010	02/17/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	02/02/2010	02/02/2010	SPI AssurantHealthandEmployeeBenef	02/17/2010	02/17/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
TIME LIMIT TO RESPOND	Note To Filer	Rosalind Minor	02/12/2010	02/12/2010
Objection on applications	Note To Reviewer	SPI AssurantHealthandEmployeeBenef	02/10/2010	02/10/2010

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Disposition

Disposition Date: 02/17/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Cover Letter	Approved-Closed	Yes
Supporting Document	Cover Letter	Replaced	Yes
Supporting Document	Statement of variability	Approved-Closed	Yes
Form *(revised)*	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes
Form *(revised)*	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes
Form *(revised)*	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes
Form *(revised)*	Preferred Rating	Approved-Closed	Yes
Form	Preferred Rating	Replaced	Yes
Form *(revised)*	Amendment	Approved-Closed	Yes
Form	Amendment	Replaced	Yes

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	02/02/2010
Submitted Date	02/02/2010
Respond By Date	

Dear Christine Fleming,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application, 29300 (Form)
- Application, 29400 (Form)
- Application, 29500 (Form)
- Preferred Rating, 26566 (Form)
- Amendment, 30216 (Form)
- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- Cover Letter (Supporting Document)
- Statement of variability (Supporting Document)

Comment:

The name of the actual insurer/underwriter of the policy and forms must not be so small as to mislead the consumer on the true identity of the insurer. The name of the insurer needs to be in close conjunction and in the same size type as the letters, initials or symbols of Assurant Health.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	02/17/2010
Submitted Date	02/17/2010

Dear Rosalind Minor,

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Comments:

Dear Ms. Minor,

Response 1

Comments: Please see the attached revised cover letter and forms.

Related Objection 1

Applies To:

- Application, 29300 (Form)
- Application, 29400 (Form)
- Application, 29500 (Form)
- Preferred Rating, 26566 (Form)
- Amendment, 30216 (Form)
- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- Cover Letter (Supporting Document)
- Statement of variability (Supporting Document)

Comment:

The name of the actual insurer/underwriter of the policy and forms must not be so small as to mislead the consumer on the true identity of the insurer. The name of the insurer needs to be in close conjunction and in the same size type as the letters, initials or symbols of Assurant Health.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Cover Letter

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application	29300		Application/Enrollment Form	Initial		51.100	29300.PDF
Previous Version							
Application	*29300*		*Application/Enrollment*	*Initial*		*51.100*	29300.PD

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

		Form			F
Application	29400	Application/Enrollment Form	Initial	51.500	29400.PDF
Previous Version					
Application	*29400*	*Application/Enrollment Form*	*Initial*	*51.500*	29400.PDF
Application	29500	Application/Enrollment Form	Initial	52.300	29500.PDF
Previous Version					
Application	*29500*	*Application/Enrollment Form*	*Initial*	*52.300*	29500.PDF
Preferred Rating	26566	Other	Initial	54.900	26566.PDF
Previous Version					
Preferred Rating	*26566*	*Other*	*Initial*	*54.900*	26566.PDF
Amendment	30216	Certificate Amendment, Insert Page, Endorsement or Rider	Initial	53.800	30216.PDF
Previous Version					
Amendment	*30216*	*Certificate Amendment, Insert Page, Endorsement or Rider*	*Initial*	*53.800*	30216.PDF

No Rate/Rule Schedule items changed.

Sincerely,
Christine Fleming

Sincerely,
SPI AssurantHealthandEmployeeBenef

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Note To Filer

Created By:
Rosalind Minor on 02/12/2010 08:06 AM
Last Edited By:
Rosalind Minor
Submitted On:
02/17/2010 09:46 AM
Subject:
TIME LIMIT TO RESPOND
Comments:

Please respond by 3/2/10.

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Note To Reviewer

Created By:

SPI AssurantHealthandEmployeeBenef on 02/10/2010 08:11 PM

Last Edited By:

Rosalind Minor

Submitted On:

02/17/2010 09:46 AM

Subject:

Objection on applications

Comments:

Dear Ms. Minor, I wanted to let you know that I am still waiting revisions on these forms from our product area, I hope to have them soon. Did you have a specific response date in mind?

Sincerely,
Christine Fleming

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Form Schedule

Lead Form Number: 29300

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/17/2010	29300	Application/ Enrollment Form	Application	Initial		51.100	29300.PDF
Approved-Closed 02/17/2010	29400	Application/ Enrollment Form	Application	Initial		51.500	29400.PDF
Approved-Closed 02/17/2010	29500	Application/ Enrollment Form	Application	Initial		52.300	29500.PDF
Approved-Closed 02/17/2010	26566	Other	Preferred Rating	Initial		54.900	26566.PDF
Approved-Closed 02/17/2010	30216	Certificate Amendment, Insert Page, Endorsement or Rider	Amendment	Initial		53.800	30216.PDF

Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENCY INFORMATION

Agent Name: _____ Phone Number: _____

Agent Number: _____ E-mail Address: _____

Key Agency Contact: _____ Agency Name: _____

Fax Number: _____ Agency Number: _____

TYPE OF ACTIVITY *(Please check appropriate box.)*

☐ **NEW** [*If not a new enrollee, check appropriate box and list affected policy number.*

☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** _____

- ☐ Internal Replacement
- ☐ Adding Dependent
- ☐ Removal of Tobacco Rates
- ☐ Applying for Preferred Rates
- ☐ Removal of Condition Specific Deductible or Special Exception Rider
- ☐ Removal/Reduction of Special Class Premium
- ☐ Conversion (over age dependent/divorce)
- ☐ Policy/Benefit Change To An Existing Policy
  List Type Of Change Requested: _____
- ☐ Reinstatement of Coverage

PERSON(S) TO BE INSURED

	Name *Last*	*First*	*M.I.*	Sex	Age	Birthdate *MM/DD/YY*	State of Birth	Height	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S)	**Name** *Last*	*First*	*M.I.*	**Sex**	**Age**	**Birthdate** *MM/DD/YY*	**Full-Time Student?**	**Height**	**Weight**	**Social Security Number**

4a. Resident Address: _____
(Street) *(City)* *(State)* *(ZIP)*

4b. E-mail Address: _____

[5.] [Does any proposed insured live outside the above household? . . . . . ☐ Yes ☐ No

If "Yes," explain. _____

[6.] [Phone Number: (_____)_____ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. (_____)_____]

Assurant Health 501 West Michigan Milwaukee, WI 53203 [Fax 414-299-6020]

7a. **Primary Insured** Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Primary Insured [self-employed] [or] [a sole proprietor]? ☐ Yes ☐ No

Is the Primary Insured covered by Workers' Compensation? ☐ Yes ☐ No

7b. **Spouse[/Domestic Partner] [/Civil Union]** Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Spouse[/Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]? ☐ Yes ☐ No

Is the Spouse[/Domestic Partner] [/Civil Union] covered by Workers' Compensation? ☐ Yes ☐ No

[**COMPLETE IF REQUESTING LIFE INSURANCE COVERAGE**

8. Beneficiary for Primary Insured: _____
(Full Name) *(Relationship)*

Contingent Beneficiary: _____
(Full Name) *(Relationship)*

The Primary Insured is the beneficiary of any Spouse [/Domestic Partner] [/Civil Union] or Child(ren) Life Insurance.]]

OTHER COVERAGE IN FORCE OR APPLIED FOR

[9.] [Are any of the proposed insureds covered by, or has application been made for any type of medical insurance? ☐ Yes ☐ No]

[If "Yes," complete the section below.

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date *(MM/DD/YY)*	Termination Date *(MM/DD/YY)*	Is this coverage being replaced by proposed coverage?

[10.] [Were all proposed insureds covered under the prior plan listed above? ☐ Yes ☐ No]

[If "No," list those not covered. _____]

[11.] [Have any of the proposed insureds ever been declined, postponed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance or had such coverage rescinded? ☐ Yes ☐ No]

[If "Yes," give details. _____

_____

HAZARDOUS ACTIVITIES AND DRIVING

[12.] [Have any of the proposed insureds [ever] [in the past [10 years]] participated in organized racing including but not limited to, automobile, motorcycle or powerboat racing or any of the following activities: skydiving; ultralight flying; scuba diving; hang gliding; rock or mountain climbing? ☐ Yes ☐ No]

[If "Yes," indicate:

Who and Which Activity	When/How Often	Do you plan continued participation?
		☐ Yes ☐ No
		☐ Yes ☐ No]

[13.] [Have any of the proposed insureds been cited for driving while intoxicated in the past [5] years or had [2] or more moving violations in the past [2] years? ☐ Yes ☐ No]

If "Yes," indicate type of violation: _____ Date(s): _____]

BILLING

[☐ Monthly Check-O-Matic] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual] [☐ List Bill *(monthly only)*]

[**Credit Card:**] [☐ First Payment Only*] [☐ Monthly] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual]

*[*With this option, you must select a secondary billing mode other than list bill for subsequent payments. Please make selection above and provide all necessary information.]*

If billing address is different than resident address, please complete:

Payor Name | Address | City | State | ZIP

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY – *Choose the following option that applies:*

☐ **To begin Check-O-Matic withdrawals:**

Select a desired withdrawal day (1–28): _____

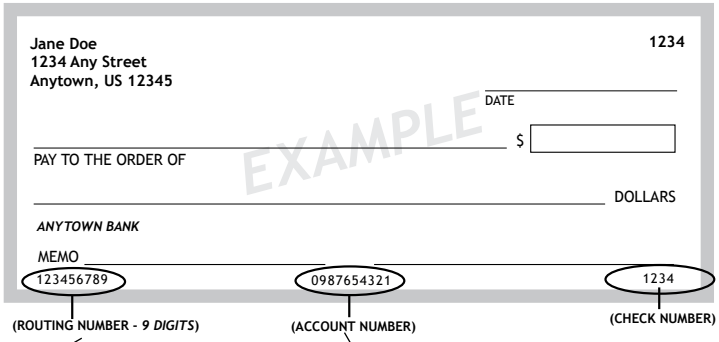
Bank Name: _____

City: _____ State: _____

☐ **To add this policy to an existing Check-O-Matic:**

Existing COM Number: _____

Associated Policy Number: _____



Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

☐ **Check-O-Matic** *(Complete authorization below)*

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signature of Payor | Date Signed

[AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

☐ VISA Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ MasterCard Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Exp. Date: _____ / _____ [Security Code Number (3 digits on back of credit card): ___ ___ ___]

Name as it appears on card: _____

Signature of Payor: _____ Date: _____]

[HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the opportunity to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure (Form JI-1033).

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

Member Signature | Date]

HEALTH STATEMENT

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH "YES" ANSWER ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.

WITHIN THE LAST [10] YEARS HAS ANY PROPOSED INSURED:

[14.][HAD ANY DIAGNOSIS OF, RECEIVED TREATMENT FOR, OR CONSULTED WITH A PHYSICIAN CONCERNING:

[a)] [The lungs or respiratory system including but not limited to: hayfever or other allergies; sinus infections; asthma; bronchitis; tuberculosis; pneumonia or emphysema? ..... ☐ Yes ☐ No]

[b)] [The heart or circulatory system including but not limited to: high blood pressure; heart attack; heart murmur; chest pain; irregular heartbeat; varicose veins; phlebitis or elevated cholesterol? ☐ Yes ☐ No] [If "Yes," please provide last known blood pressure and cholesterol reading on the "Additional Medical Details" page].]

[c)] [The digestive system including but not limited to: ulcer; gastritis; heartburn; intestinal disorder; colitis; gallbladder; hemorrhoids; hernia; disorder of the pancreas; spleen; or liver including but not limited to; hepatitis; jaundice or cirrhosis? ..... ☐ Yes ☐ No]

[d)] [The nervous system including but not limited to: epilepsy; seizures; unconsciousness; convulsions; vertigo; headaches; paralysis; multiple sclerosis; cerebral palsy; Parkinson's disease; stroke or mini-stroke; TIA or brain attack? ..... ☐ Yes ☐ No]

[e)] [Mental disease or nervous disorder including but not limited to: any emotional disorder; anxiety; depression; attention deficit disorder; eating disorder; or psychiatric treatment or counseling? ... ☐ Yes ☐ No]

[f)] [Congenital disorder, birth defects or developmental disorders including but not limited to Down Syndrome; mental retardation; autism; cleft palate; club foot; or congenital heart defects? ☐ Yes ☐ No]

[g)] [The genitourinary system including but not limited to: any kidney disorder; kidney stones; cystitis; prostatitis; bladder infections; or sexually transmitted disease? ..... ☐ Yes ☐ No]

[h)] [Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder? ☐ Yes ☐ No]

[i)] [The muscular, skeletal or connective tissue disorder including but not limited to: arthritis; lupus (SLE); temporomandibular joint disease (TMJ); any back or spine disorder or treatment of any muscular or neuromuscular disorder or any manipulation therapy? ..... ☐ Yes ☐ No]

[j)] [Blood or lymph disorders including but not limited to anemia or lymphadenopathy? ..... ☐ Yes ☐ No]

[k)] [Cancer? ..... ☐ Yes ☐ No] [If "Yes," provide location, type of cancer and treatment received on the "Additional Medical Details" page].]

[l)] [Tumor, cyst or growth of any kind; any breast or skin disorders? ..... ☐ Yes ☐ No] [If "Yes," provide location, state if treated or removed and date on the "Additional Medical Details" page].]

[m)][Any disorder of the eyes; ears (including ear infections or ear tubes); nose or throat. Tonsils or adenoids; any speech or hearing impairment? ..... ☐ Yes ☐ No]

[n-1)][Any disorder of the reproductive organs, including but not limited to: disorders of the penis; testes; vagina; ovaries and cervix; uterus; diagnosed or treated for infertility or irregular menstruation? ☐ Yes ☐ No]

[n-2)] [To the best of your knowledge, are you, your spouse [/domestic partner] [/civil union] or any dependent now pregnant? ..... ☐ Yes ☐ No]

[n-3)] [Is any person not named on this enrollment form now pregnant by any person to be insured? ... ☐ Yes ☐ No]

IF EITHER [N-2] OR [N-3] IS ANSWERED "YES," MEDICAL COVERAGE CANNOT BE ISSUED.

QUESTIONS N-4 – N-6 FOR FEMALE APPLICANTS:

[n-4)][Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage? ..... ☐ Yes ☐ No]

[n-5)][Date of Last Pap Smear: _____ Results: _____]

[n-6)][Have you been instructed to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear? ..... ☐ Yes ☐ No]

[15.] [Been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession? ..... ☐ Yes ☐ No]

[16.] [Been diagnosed as having or been treated for any immune deficiency disorder by a member of the medical profession? ..... ☐ Yes ☐ No]

[17.] [Experienced any of the following: Signs and symptoms of an immune deficiency disorder may include lymphadenopathy (swollen lymph nodes); loss of appetite; weight loss; chronic fatigue; fever; oral thrush; skin rashes; unexplained infections; dementia; depression; or other psychoneurotic disorders with no known cause? ..... ☐ Yes ☐ No]

[18.] [Had surgery or has diagnostic testing, treatment or surgery been recommended or scheduled that has not been completed? ..... ☐ Yes ☐ No]

HEALTH STATEMENT *CONTINUED*

[19.] [Does any person have any fixation/prosthetic devices present including but not limited to: plates; screws; pins; implants (including breast implants); shunts; pacemakers or valve replacements? ..... ☐ Yes ☐ No]

[20.] [Had an electrocardiogram, chest x-ray, or blood test or any other diagnostic testing of any kind or been hospital confined in the past [10] years? ..... ☐ Yes ☐ No]

[If "Yes," give name of physician or hospital and results on the "Additional Medical Details" page].]

[21.] [Been a member of Alcoholics Anonymous or had any treatment, including but not limited to, counseling for alcoholism or alcohol abuse or been advised by a physician to discontinue or decrease alcohol consumption?..... ☐ Yes ☐ No]

[22.] [Used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs; or received treatment for drug abuse or chemical dependency?..... ☐ Yes ☐ No]

ADDITIONAL QUESTIONS

[23.] [To the best of your knowledge, does any person to be insured have any mental or physical impairment, disease or deformity not indicated above? ..... ☐ Yes ☐ No]

[24a.] [Have you or your spouse [/domestic partner] [/civil union] (if to be insured) smoked cigarettes or used tobacco in any form or nicotine substitute within the past year? PRIMARY INSURED..... ☐ Yes ☐ No]

[SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION] (if to be insured)..... ☐ Yes ☐ No]

[24b.] [Have you or your spouse [/domestic partner] [/civil union] EVER smoked cigarettes or used tobacco products? ..... ☐ Yes ☐ No]

[If "Yes," indicate who, amount per day and year quit on the "Additional Medical Details" page].]

[25.] [Is any proposed insured currently taking, or taken within the past [12] months, any prescription medication, or receiving medical treatment of any kind [or is currently taking, or taken, any non prescription medication on a daily basis]? ..... ☐ Yes ☐ No]

[If "Yes," provide details of treatment including name and dosage of all medications on the "Additional Medical Details" page].]

REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE

[26.] [Has there been any medical treatment or medication use for, or have you consulted with a physician concerning the condition(s) which has had a Condition Specific Deductible, been ridered or rated since the covered person's effective date? ..... ☐ Yes ☐ No]

[If "Yes," provide details on the "Additional Medical Details" page].]

OTHER PHYSICIANS

[27.] [Regular physician or medical practitioner for each proposed insured. If none, provide last physician seen, date, reason and results.

Primary Proposed Insured's Physician _____

Address _____

Date Last Seen_____ Reason & Results _____

Spouse's [/Domestic Partner's] [/Civil Union's] Physician _____

Address _____

Date Last Seen_____ Reason & Results _____

Child's Name_____ Physician _____

Address _____

Date Last Seen_____ Reason & Results _____

Child's Name_____ Physician _____

Address _____

Date Last Seen_____ Reason & Results _____

Child's Name_____ Physician _____

Address _____

Date Last Seen_____ Reason & Results _____]

ADDITIONAL MEDICAL DETAILS

Attach a separate sheet if additional space is needed. Date and sign any additional sheets.

	Provide Dates, Type of Treatment and Results	Name of Doctor/Hospital and Complete Address and Phone Number
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
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Person: **Condition:** **Question #:**		

[EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? ..... ☐ Yes ☐ No]

AUTHORIZATION

[I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. The enrollment form and any amendments shall be the basis for the contract. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date we receive the enrollment form; B) the requested Effective Date. A change in the health of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company. The contract may only be effective prior to the contract delivery subject to the terms of the Conditional Receipt.]

[I agree that a photographic copy of this authorization shall be valid for two years from the date signed.]

[I acknowledge receiving the notification regarding [MIB, Inc.,] the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.]

[We, the undersigned Proposed Insured(s) and agent, acknowledge that the Proposed Insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.]

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, [MIB Inc.], consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, [EMSI] and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to [MIB, Inc.] and any medical records company engaged by Time Insurance Company, including but not limited to [EMSI] and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

_____
Signature of Primary Proposed Insured

_____
Signature of Spouse[/Domestic Partner] [/Civil Union] or Other ***(if proposed to be insured)***

_____
Signature(s) of Other Dependent(s) 18 or Over ***(if proposed to be insured)***

_____
Guardian's Signature

Requested Effective Date: _____

Premium Amount Sent: $ _____

One-time Processing Fee Sent*: _____
**Not applicable in all states*

Conditional Receipt Taken: ☐ **Yes** ☐ **No**

_____ _____ A.M. / P.M. _____ _____
Date Signed **Time Signed** **City** **State**

Attention: (Agent)
I have reviewed this enrollment form to ensure that all required items have been completed.

To the best of knowledge, there ☐ **IS** ☐ **IS NOT** a replacement of medical insurance involved in this transaction.

Are you aware of any mental or physical impairment, disease, or deformity of any proposed insured which is not disclosed on the enrollment form? ☐ **Yes** ☐ **No**

If "Yes," please explain. _____

_____

_____
Licensed Resident Agent's Signature

_____
Print Agent's Name

_____ Initial here if you witnessed the signing of this form by the proposed insured.

[ADDITIONAL NOTICES

[NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]
Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB,] upon request, will supply such company with the information about you in its file.
Upon receipt of a request from you, [MIB] will arrange disclosure of any information in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].
Time Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES
To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY
We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]

[CONDITIONAL RECEIPT

This Conditional Receipt is received from _____, this _____ day of

_____ *(month)* _____ *(year)*.

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which Time Insurance Company receives the application at its home office.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned.

If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company receives the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.]

Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

AGENT/AGENCY INFORMATION

Agent Name: _____ Phone Number: _____

Agent Number: _____ E-mail Address: _____

Key Agency Contact: _____ Agency Name: _____

Fax Number: _____ Agency Number: _____

TYPE OF ACTIVITY *(Please check appropriate box.)*

☐ **NEW** [*If not a new enrollee, check appropriate box and list affected policy number.*

☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** _____

☐ Internal Replacement ☐ Conversion (over age dependent/divorce)

PERSON(S) TO BE INSURED

	Name *Last* *First* *MI*	Sex	Age	Birthdate *(MM/DD/YY)*	State of Birth	Social Security Number
1. PRIMARY						
2. SPOUSE[/ DOMESTIC PARTNER] [/CIVIL UNION]						
3. DEPENDENT(S) *(list relationship)*	**Name** *Last* *First* *MI*	**Sex**	**Age**	**Birthdate** *(MM/DD/YY)*	**Full-time Student?**	**Social Security Number**

4. Resident Address: _____
(NO P.O. BOXES) *(Street)* *(City)* *(State)* *(ZIP)*

[5.] [Phone Number: (_____) _____ 6. E-mail Address: _____]

7a. Are any of the proposed insureds covered by any type of medical insurance? . . . . . ☐ Yes (Complete section below)

. . . . . ☐ No (Go to BILLING)

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date *(MM/DD/YY)*	Termination Date *(MM/DD/YY)*	Is this coverage being replaced by proposed coverage?

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

7b. Primary Insured Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Primary insured [self-employed] [or] [a sole proprietor]? . . . . . ☐ Yes ☐ No

Is the Primary Insured covered by Workers' Compensation? . . . . . ☐ Yes ☐ No

7c. Spouse [/Domestic Partner] [/Civil Union] Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Spouse[/ Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]? . . . . . ☐ Yes ☐ No

Is the Spouse[/ Domestic Partner] [/Civil Union] covered by Workers' Compensation?. . . . . ☐ Yes ☐ No

BILLING

[☐ Monthly Check-O-Matic] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual] [☐ List Bill *(monthly only)*]

[Credit Card:] [☐ First Payment Only*] [☐ Monthly] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual]

*[*With this option, you must select a secondary billing mode other than list bil for subsequent payments. Please make selection above and provide all necessary information.]*

If billing address is different than resident address, please complete:

Payor Name _____ Address _____ City _____ State _____ ZIP _____

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY – *Choose the following option that applies:*

☐ **To begin Check-O-Matic withdrawals:**

Select a desired withdrawal day (1–28): _____

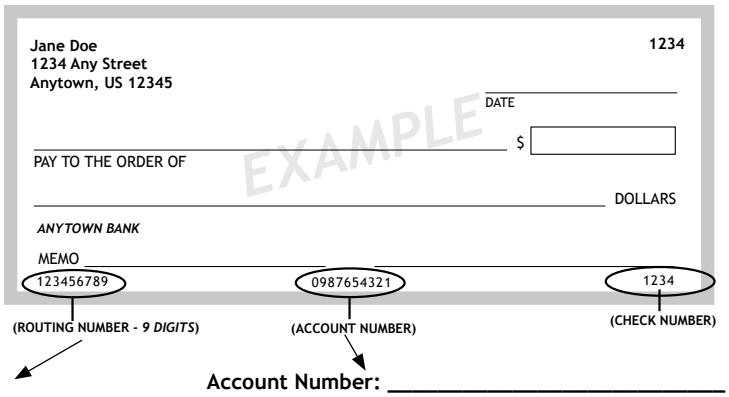
Bank Name: _____

City: _____ State: _____

☐ **To add this policy to an existing Check-O-Matic:**

Existing COM Number: _____

Associated Policy Number: _____



Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

☐ **Check-O-Matic** *(Complete authorization below)*

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

_____ _____

Signature of Payor Date Signed

[AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

☐ VISA Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ MasterCard Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Exp. Date: _____ / _____ [Security Code Number (3 digits on back of credit card): ___ ___ ___]

Name as it appears on card: _____

Signature of Payor: _____ Date: _____]

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

[COMPLETE IF REQUESTING LIFE INSURANCE COVERAGE

Beneficiary for Primary Insured: _____

(Full Name) *(Relationship)*

Contingent Beneficiary: _____

(Full Name) *(Relationship)*

The Primary Insured is the beneficiary of any Spouse [/Domestic Partner] [/Civil Union] or Child(ren) Life Insurance.]

HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the opportunity to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure (Form JI-1033).

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

_____

Member Signature Date

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

[EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are personally paying the entire premium for this health Insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? . . . . . ☐ Yes ☐ No]

[AUTHORIZATION

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, [MIB, Inc.,] employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Time Insurance Company. (2) Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (3) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (4) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, [MIB, Inc.,] consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, [EMSI] and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to [MIB, Inc.] and any medical records company engaged by Time Insurance Company, including but not limited to [EMSI] and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

Signature of Primary Proposed Insured	Signature of Spouse or Other Insured (if proposed to be insured)
(Circle one) A.M. / P.M.	
Date Signed / Time Signed / City & State	Requested Policy Effective Date

Conditional Receipt Given? ❑ Yes ❑ No

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

ADDITIONAL NOTICES

[NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]
Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB,] upon request, will supply such company with the information about you in its file.
Upon receipt of a request from you, [MIB] will arrange disclosure of any information in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].
Time Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES
To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY
We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

CONDITIONAL RECEIPT

This Conditional Receipt is received from _____, this_____ day of _____ *(month)*

_____*(year)*.

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which the Personal Health History call is completed.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned. If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date on which the Personal Health History call is completed. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.

LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX

Policy #: _____

Acceptance of Offer and Attestation

I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. My recorded Personal Health History, the enrollment form and any amendments shall be the basis for the offer of coverage. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. I shall sign the enrollment form and obtain the signatures of my Spouse [Domestic Partner] [Civil Union] and any covered dependents over the age of 18, and return it to Time Insurance Company within 30 days of the contract issue. If acceptance is not received within 30 days, Time Insurance Company reserves the right to revoke any and all such offers. The first full premium must be paid. The contract may only be effective prior to the contract delivery and acceptance, if all the terms of the Conditional Receipt have been fulfilled.

I agree that a photocopy of this authorization shall be valid for two years from the date signed. I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding the Medical Information Bureau, the Privacy statement concerning my personal health information, the Abbreviated Notice of Insurance Information Practices, and the Outline of Coverage for Health Insurance, if required.

We, the undersigned proposed insured(s) and agent acknowledge that the proposed insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

_____

Signature of Proposed Insured

_____ _____

Date Signed State

_____

Signature of Spouse or Other Insured

_____

Signature(s) of Other Dependents 18 or Over

_____

Guardian's Signature

[If Life Insurance is issued, complete this section.

Beneficiary for Primary Insured:

_____

Full Name and Relationship

Contingent Beneficiary:

_____

Full Name and Relationship

(The Primary Insured is the Beneficiary of any spouse [/domestic partner] [/civil union] or child(ren) life insurance.)]

Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENCY INFORMATION

Agent Name: _____ Phone Number: _____

Agent Number: _____ E-mail Address: _____

Key Agency Contact: _____ Agency Name: _____

Fax Number: _____ Agency Number: _____

TYPE OF ACTIVITY *(Please check appropriate box.)*

☐ **NEW** *If not a new enrollee, check appropriate box and list affected policy number.*

☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** _____

☐ Internal Replacement ☐ Conversion (over age dependent/divorce)

PERSON(S) TO BE INSURED

	Name *Last*	*First*	*M.I.*	Sex	Age	Birthdate *MM/DD/YY*	State of Birth	Height	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S)	**Name** *Last*	*First*	*M.I.*	**Sex**	**Age**	**Birthdate** *MM/DD/YY*	**Full-Time Student?**	**Height**	**Weight**	**Social Security Number**

4a. Resident Address: _____
(Street) (City) (State) (ZIP)

4b. E-mail Address: _____

[5.] [Does any proposed insured live outside the above household? . . . . . ☐ Yes ☐ No
If "Yes," explain. _____]

[6.] [Phone Number: (_____) _____ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. (_____) _____]

[7a.] **Primary Insured** Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Primary Insured [self-employed] [or] [a sole proprietor]? . . . . . ☐ Yes ☐ No

Is the Primary Insured covered by Workers' Compensation? . . . . . ☐ Yes ☐ No

[7b.] **Spouse[/Domestic Partner] [/Civil Union]** Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Spouse[/Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]? . . . . . ☐ Yes ☐ No

Is the Spouse[/Domestic Partner] [/Civil Union] covered by Workers' Compensation? . . . . . ☐ Yes ☐ No

OTHER COVERAGE IN FORCE OR APPLIED FOR

[8.] [Are any of the proposed insureds covered by, or has application been made for any type of medical insurance? . . . . . ☐ Yes ☐ No]

[If "Yes," complete the section below.

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date *(MM/DD/YY)*	Termination Date *(MM/DD/YY)*	Is this coverage being replaced by proposed coverage?

]

[9.] [Were all proposed insureds covered under the prior plan listed above? . . . . . ☐ Yes ☐ No]

[10.] [Have any of the proposed insureds within the last [10] years been declined, postponed, rescinded, reformed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance? . . . . . ☐ Yes ☐ No]

If "Yes," give details. _____

_____]

HAZARDOUS ACTIVITIES AND DRIVING

[11.] [In the last [10] years, have any of the proposed insureds participated in any motorized vehicle racing (includes drivers, pit crew, owners or mechanics) or any of the following activities: skydiving, ultralight flying, scuba diving, hang gliding, rock or mountain climbing or rodeo participation? . . . . . ☐ Yes ☐ No]

[12.] [In the last [10] years, have any of the proposed insureds been cited for operating a motor vehicle under the influence of alcohol or drugs? . . . . . ☐ Yes ☐ No]

BILLING

[☐ Monthly Check-O-Matic] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual] [☐ List Bill *(monthly only)*]

[**Credit Card:**] [☐ First Payment Only*] [☐ Monthly] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual]

*[*With this option, you must select a secondary billing mode other than list bill for subsequent payments. Please make selection above and provide all necessary information.]*

If billing address is different than resident address, please complete:

Payor Name _____ Address _____ City _____ State _____ ZIP _____

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY - *Choose the following option that applies:*

☐ **To begin Check-O-Matic withdrawals:**

Select a desired withdrawal day (1–28): _____

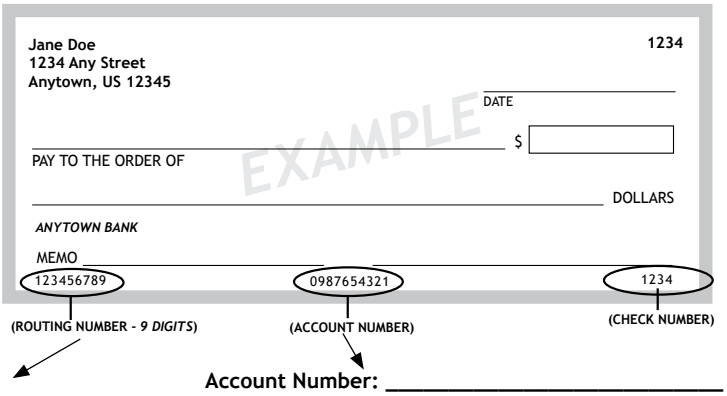
Bank Name: _____

City: _____ State: _____

☐ **To add this policy to an existing Check-O-Matic:**

Existing COM Number: _____

Associated Policy Number: _____



Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

☐ **Check-O-Matic** *(Complete authorization below)*

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signature of Payor _____ Date Signed _____

[AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

☐ VISA Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ MasterCard Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Exp. Date: _____ / _____ [Security Code Number (3 digits on back of credit card): ___ ___ ___]

Name as it appears on card: _____

Signature of Payor: _____ Date: _____]

HEALTH STATEMENT

For Questions [13]-[25,] WITHIN THE LAST [10] YEARS, HAS ANY PROPOSED INSURED:

[Note: any follow-up visits in the last [10] years as a result of a diagnosis over [10] years ago must be disclosed.]

[13.] [Had surgery [in a hospital or outpatient facility]? ..... ☐ Yes ☐ No]

[14.] [Had medical treatment [in a hospital or outpatient facility]? ..... ☐ Yes ☐ No]

[15.] [Had any urgent care or emergency room visits]? ..... ☐ Yes ☐ No]

[16.] [Received treatment, testing, consulted with or received a diagnosis from a physician or healthcare provider? Do NOT include annual physical exams]. ..... ☐ Yes ☐ No]

[17.] [Had any testing with [abnormal findings] or tests for which you have not received results? ..... ☐ Yes ☐ No]

[18.] [Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed? ..... ☐ Yes ☐ No]

[19.] [Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups? ..... ☐ Yes ☐ No]

[20.] [Used illegal drugs or prescription medication other than as prescribed or been advised by a physician or health care provider to discontinue or decrease alcohol consumption or drug use? ..... ☐ Yes ☐ No]

Additional Questions

[21.] [Has any proposed insured taken or been advised to take any prescription medication in the last [[10] years] [[12] months]? ..... ☐ Yes ☐ No]

[22.] [Has any proposed adult [ever] used tobacco products in any form or nicotine substitutes within the last [10] years]? ..... ☐ Yes ☐ No]

[23.] [Has any proposed insured had a diagnosis, treatment or follow-up for cancer in the last [10] years? ..... ☐ Yes ☐ No]

[24.] [Is any proposed insured currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy? ..... ☐ Yes ☐ No]

[25.] [Have you fully disclosed all medical conditions for you and your family within the last [10] years? ... ☐ Yes ☐ No]

ADDITIONAL NOTICES

[NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB,] upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

Time Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

ADDITIONAL NOTES

EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly. Do you agree with this statement? ..... ☐ Yes ☐ No]

AUTHORIZATION

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, [MIB, Inc.,] employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Time Insurance Company. (2) Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (3) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (4) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, [MIB, Inc.,] consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, [EMSI] and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to [MIB, Inc.] and any medical records company engaged by Time Insurance Company, including but not limited to [EMSI] and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

_____	_____	_____ A.M./P.M.	_____	_____
Signature of Primary Proposed Insured	**Date Signed**	**Time Signed**	**City**	**State**

Signature of Spouse[/Domestic Partner] [/Civil Union] or Other *(if proposed to be insured)*

Signature(s) of Other Dependent(s) 18 or Over *(if proposed to be insured)*

Guardian's Signature

Requested Effective Date: _____ **Premium Amount Sent: $** _____ **One-time Processing Fee Sent*:** _____]

**Not applicable in all states*

Preferred Rating Questionnaire

Time Insurance Company
501 W. Michigan Street
[P.O. Box 624]
Milwaukee, WI 53201-0624
[800-800-1212]

Complete this questionnaire to determine eligibility for the **Preferred** or **Preferred Smoker** rating classes.

_____

Primary Proposed Insured's Name (please print)

*Note: A proposed insured *may* be eligible for a Preferred Smoker rating if he or she is able to truthfully answer questions [2,] [3] and [4] "No." Underwriting reserves the right to apply tobacco ratings based upon lab results, phone verification or medical records.

Each proposed insured must complete and sign the appropriate sections. Spouses/Other Insured are considered separately for preferred rating eligibility and must also answer this questionnaire. This information is not required for dependents.

	PRIMARY	**SPOUSE /OTHER INSURED**
[1.] [Has the proposed insured used tobacco products at any time during the past 3 years? (If NO, go to question [5].)	☐ Yes ☐ No	☐ Yes ☐ No]
[2.] [Did the proposed insured previously smoke or do they currently smoke 10 or more cigarettes per day?	☐ Yes ☐ No	☐ Yes ☐ No]
[3.] [Did the proposed insured previously smoke or do they currently smoke more than 1 cigar or pipe per day?	☐ Yes ☐ No	☐ Yes ☐ No]
[4.] [Did the proposed insured previously use or do they currently use chewing tobacco?	☐ Yes ☐ No	☐ Yes ☐ No]
[5.] [Is the proposed insured currently outside the weight range listed in the build chart?	☐ Yes ☐ No	☐ Yes ☐ No]
[6.] [Has the proposed insured had blood pressure readings in excess of 140/90 or been treated for elevated blood pressure in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No]
[7.] [Has the proposed insured had cholesterol readings above 220 or a cholesterol/HDL ratio above 3.5 or been treated for elevated cholesterol or triglycerides within the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No]
[8.] [Has the proposed insured had any citations for DUI or more than 1 moving violation including speeding ticket(s) within the past 2 years?	☐ Yes ☐ No	☐ Yes ☐ No]
[9.] [Has the proposed insured had a complete physical exam within the past 3 years?**	☐ Yes ☐ No	☐ Yes ☐ No]

** *Individuals age 40 and over must have had a physical exam in the past 3 years to qualify for preferred rates.*

_____ _____

Primary Proposed Insured Signature *Date* *Spouse or Other Insured Signature* *Date*

_____ _____

Driver's License Number *Driver's License Number*

_____ _____

Licensed Agent Signature *Date* *Agent Number*

Time Insurance Company
501 W. Michigan Street
[P.O. Box 624]
Milwaukee, WI 53201-0624
[800-800-1212]

AMENDMENT OF APPLICATION/ENROLLMENT FORM

I, [John Doe], hereby amend my application/enrollment form to Time Insurance Company dated [December 03, 2009] as follows:

[Insert Amendment Verbiage Here.]

*****PLEASE READ AND COMPLETE THE FOLLOWING:*****

I hereby represent that the above statements are true and complete to the best of my knowledge and belief. I agree that this form shall be an amendment to the original application/enrollment form and of any [policy]/[certificate] issued hereunder. I also agree that no coverage shall be in effect until this form shall have been completed and the full premium paid.

Accepted at:

_____ _____

City or Town, State. Date.

Signature of Insured (listed above): **X** _____

[John Doe]
(If minor, legal guardian signature needed)

[Signature of Owner/Primary Insured:] **X** [_____]

[(If minor, legal guardian signature needed)]

[Agent's Signature:] **X** [_____]

Policy/Certificate No. [000012345]

30216

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/17/2010

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/17/2010

Bypass Reason: This is an application filing. Please see form schedule.

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	02/17/2010

Comments:

Attachment:

Cover Letter.PDF

		Item Status:	Status Date:
Satisfied - Item:	Statement of variability	Approved-Closed	02/17/2010

Comments:

Attachment:

Statement of variability.PDF

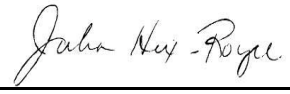
STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Time Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
29300	51.1
29400	51.5
29500	52.3
26566	54.9
30216	53.8

Signed: 

Name: Julia Hix-Royer
VP Regulatory Compliance& AH

Title: Compliance Officer

Date: January 28,2010

ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

February 17, 2010

Arkansas Department of Insurance
1200 W. Third Street
Arkansas Department of Insurance

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Enrollment Form for Medical Insurance for Individuals and Families: 29300 (Rev. 1/2010)
Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and Families: 29400 (Rev. 1/2010)
Tele-App Part 2 Enrollment Form for Medical Insurance for Individuals and Families: 29500 (Rev. 1/2010)
Preferred Rating Questionnaire: 26566
Amendment of Enrollment form: 30216

Dear Ms. Minor:

In response to the objections raised by you in your SERFF response of February 2, 2010. We have addressed the objections in the same order in which they were presented in your letter

1. The name of the actual insurer/underwriter of the policy must not be so small as to mislead the consumer on the true identity of the insurer. The name of the insurer needs to be in close conjunction and in the same size type as the letters, initials or symbols of Assurant Health.

RESPONSE: The logo has been removed and the font for the insurer/underwriter name has been enlarged.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Christine R. Fleming
Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168

ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

STATEMENT OF VARIABILITY

- A number of benefit options and/or items which customarily vary according to the Policyholder's specific plan of insurance, which will allow us to deliver a customized contract to our customers reflecting all benefit options selected, helping to alleviate any ambiguity on the part of the customers as to what is covered and how it is covered.
- Flexibility in utilizing provisions when filing diverse products.
- Future flexibility to adjust to changing regulatory and market needs.

1. All bracketed numbers (excluding form numbers) are variable, subject to the confines of state and federal law. Bracketed benefit amounts, illustrated as a range, list of amounts or otherwise, are variable and can fluctuate to provide a richer benefit to the insured than what is represented in the approved document.

2. All bracketed text varies to the extent that such language may be:

    a. included as shown;
    b. omitted in its entirety;
    c. rearranged; or
    d. transferred to another provision, section or page.

3. All bracketed numbers and/or text will be varied only:

    a. within any statutory or regulatory requirements; and
    b. under the condition that the numerical value(s) and benefit language is within the intent and framework of the actual approved provision.

We also reserve the right to amend the form(s) to correct any minor clerical or typographical errors we may have overlooked prior to approval, and to revise any phraseology to clarify the intent within the confines of the law.

SERFF Tracking Number:	*ASWX-126478651*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*44723*
Company Tracking Number:	*IHAR01145FIF01*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR01145FIF01*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/28/2010	Form	Application	02/17/2010	29300.PDF (Superceded)
01/28/2010	Form	Application	02/17/2010	29400.PDF (Superceded)
01/28/2010	Form	Application	02/17/2010	29500.PDF (Superceded)
01/28/2010	Form	Preferred Rating	02/17/2010	26566.PDF (Superceded)
01/28/2010	Form	Amendment	02/17/2010	30216.PDF (Superceded)
01/28/2010	Supporting Document	Cover Letter	02/17/2010	Cover Letter.PDF (Superceded)

Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENCY INFORMATION

Agent Name: _____ Phone Number: _____

Agent Number:_____ E-mail Address: _____

Key Agency Contact: _____ Agency Name: _____

Fax Number:_____ Agency Number:_____

[Policy should be mailed to:] [☐ Agent] [☐ Agency] [☐ Policyholder]

TYPE OF ACTIVITY *(Please check appropriate box.)*

[☐ **NEW**] [*If not a new enrollee, check appropriate box and list affected policy number.]*

[☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** _____]

[☐ Internal Replacement]
[☐ Adding Dependent]
[☐ Removal of Tobacco Rates]
[☐ Applying for Preferred Rates]
[☐ Removal of Condition Specific Deductible or Special Exception Rider]
[☐ Removal/Reduction of Special Class Premium]
[☐ Conversion (over age dependent/divorce)]
[☐ Policy/Benefit Change To An Existing Policy]
[*List Type Of Change Requested:* _____]
[☐ Reinstatement of Coverage]

PERSON(S) TO BE INSURED

	Name *Last*	*First*	*M.I.*	Sex	Age	Birthdate *MM/DD/YY*	State of Birth	Height	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S)	**Name** *Last*	*First*	*M.I.*	**Sex**	**Age**	**Birthdate** *MM/DD/YY*	**Full-Time Student?**	**Height**	**Weight**	**Social Security Number**

4a. Resident Address: _____
(Street) *(City)* *(State)* *(ZIP)*

4b. E-mail Address: _____

5. Does any proposed insured live outside the above household? . . . . . ☐ Yes ☐ No
If "Yes," explain. _____

6. Phone Number: (_____) _____ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. (_____)_____]

Assurant Health 501 West Michigan Milwaukee, WI 53203 [Fax 414-299-6020]
Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

7a. **Primary Insured** Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Primary Insured [self-employed] [or] [a sole proprietor]? ☐ Yes ☐ No

Is the Primary Insured covered by Workers' Compensation? ☐ Yes ☐ No

7b. **Spouse[/Domestic Partner] [/Civil Union]** Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Spouse[/Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]? ☐ Yes ☐ No

Is the Spouse[/Domestic Partner] [/Civil Union] covered by Workers' Compensation? ☐ Yes ☐ No

COMPLETE IF REQUESTING LIFE INSURANCE COVERAGE

8. Beneficiary for Primary Insured: _____
(Full Name) *(Relationship)*

Contingent Beneficiary: _____
(Full Name) *(Relationship)*

The Primary Insured is the beneficiary of any Spouse [/Domestic Partner] [/Civil Union] or Child(ren) Life Insurance.

OTHER COVERAGE IN FORCE OR APPLIED FOR

[9.] [Are any of the proposed insureds covered by, or has application been made for any type of medical insurance? ☐ Yes ☐ No]

[If "Yes," complete the section below.

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date *(MM/DD/YY)*	Termination Date *(MM/DD/YY)*	Is this coverage being replaced by proposed coverage?

]

[10.] [Were all proposed insureds covered under the prior plan listed above? ☐ Yes ☐ No]

[If "No," list those not covered. _____]

[11.] [Have any of the proposed insureds ever been declined, postponed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance or had such coverage rescinded? ☐ Yes ☐ No]

[If "Yes," give details. _____

_____

HAZARDOUS ACTIVITIES AND DRIVING

[12.] [Have any of the proposed insureds [ever] [in the past [10 years]] participated in organized racing including but not limited to, automobile, motorcycle or powerboat racing or any of the following activities: skydiving; ultralight flying; scuba diving; hang gliding; rock or mountain climbing? ☐ Yes ☐ No]

[If "Yes," indicate:

Who and Which Activity	**When/How Often**	**Do you plan continued participation?**
		☐ Yes ☐ No
		☐ Yes ☐ No

]

[13.] [Have any of the proposed insureds been cited for driving while intoxicated in the past 5 years or had 2 or more moving violations in the past 2 years? ☐ Yes ☐ No]

[If "Yes," indicate type of violation: _____ Date(s): _____]

BILLING

[☐ Monthly Check-O-Matic] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual] [☐ List Bill *(monthly only)*]

[**Credit Card:**] [☐ First Payment Only*] [☐ Monthly] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual]

*[*With this option, you must select a secondary billing mode for subsequent payments. Please make selection above and provide all necessary information.]*

If billing address is different than resident address, please complete:

Payor Name Address City State ZIP

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY – *Choose the following option that applies:*

☐ **To begin Check-O-Matic withdrawals:**

Select a desired withdrawal day (1–28): _____

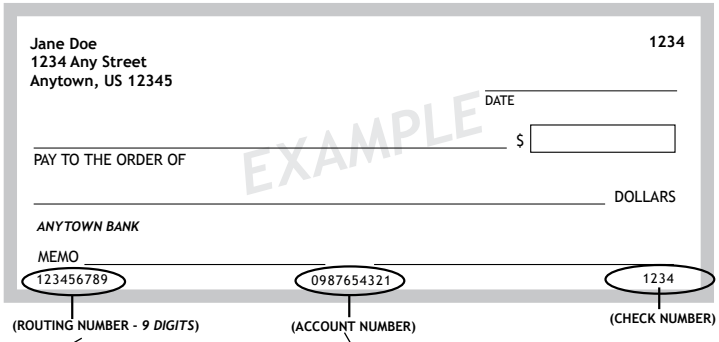
Bank Name: _____

City: _____State: _____

☐ **To add this policy to an existing Check-O-Matic:**

Existing COM Number: _____

Associated Policy Number: _____



Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

☐ **Check-O-Matic** *(Complete authorization below)*

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signature of Payor Date Signed

[AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

☐ VISA Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ MasterCard Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Exp. Date: _____ / _____ [Security Code Number (3 digits on back of credit card): ___ ___ ___]

Name as it appears on card:_____

Signature of Payor: _____ Date: _____]

[HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the opportunity to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure (Form JI-1033).

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

Member Signature Date]

HEALTH STATEMENT

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH "YES" ANSWER ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

[14.]HAD ANY DIAGNOSIS OF, RECEIVED TREATMENT FOR, OR CONSULTED WITH A PHYSICIAN CONCERNING:

[a)] [The lungs or respiratory system including but not limited to: hayfever or other allergies; sinus infections; asthma; bronchitis; tuberculosis; pneumonia or emphysema? ..... ☐ Yes ☐ No]

[b)] [The heart or circulatory system including but not limited to: high blood pressure; heart attack; heart murmur; chest pain; irregular heartbeat; varicose veins; phlebitis or elevated cholesterol? ☐ Yes ☐ No]
[If "Yes," please provide last known blood pressure and cholesterol reading [on the "Additional Medical Details" page].]

[c)] [The digestive system including but not limited to: ulcer; gastritis; heartburn; intestinal disorder; colitis; gallbladder; hemorrhoids; hernia; disorder of the pancreas; spleen; or liver including but not limited to; hepatitis; jaundice or cirrhosis? ..... ☐ Yes ☐ No]

[d)] [The nervous system including but not limited to: epilepsy; seizures; unconsciousness; convulsions; vertigo; headaches; paralysis; multiple sclerosis; cerebral palsy; Parkinson's disease; stroke or mini-stroke; TIA or brain attack? ..... ☐ Yes ☐ No]

[e)] [Mental disease or nervous disorder including but not limited to: any emotional disorder; anxiety; depression; attention deficit disorder; eating disorder; or psychiatric treatment or counseling? ... ☐ Yes ☐ No]

[f)] [Congenital disorder, birth defects or developmental disorders including but not limited to Down Syndrome; mental retardation; autism; cleft palate; club foot; or congenital heart defects? ☐ Yes ☐ No]

[g)] [The genitourinary system including but not limited to: any kidney disorder; kidney stones; cystitis; prostatitis; bladder infections; or sexually transmitted disease? ..... ☐ Yes ☐ No]

[h)] [Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder? ☐ Yes ☐ No]

[i)] [The muscular, skeletal or connective tissue disorder including but not limited to: arthritis; lupus (SLE); temporomandibular joint disease (TMJ); any back or spine disorder or treatment of any muscular or neuromuscular disorder or any manipulation therapy? ..... ☐ Yes ☐ No]

[j)] [Blood or lymph disorders including but not limited to anemia or lymphadenopathy? ..... ☐ Yes ☐ No]

[k)] [Cancer? ..... ☐ Yes ☐ No]
[If "Yes," provide location, type of cancer and treatment received [on the "Additional Medical Details" page].]

[l)] [Tumor, cyst or growth of any kind; any breast or skin disorders? ..... ☐ Yes ☐ No]
[If "Yes," provide location, state if treated or removed and date [on the "Additional Medical Details" page].]

[m)] [Any disorder of the eyes; ears (including ear infections or ear tubes); nose or throat. Tonsils or adenoids; any speech or hearing impairment? ..... ☐ Yes ☐ No]

[n-1)] [Any disorder of the reproductive organs, including but not limited to: disorders of the penis; testes; vagina; ovaries and cervix; uterus; diagnosed or treated for infertility or irregular menstruation? ☐ Yes ☐ No]

[n-2)] [To the best of your knowledge, are you, your spouse [/domestic partner] [/civil union] or any dependent now pregnant? ..... ☐ Yes ☐ No]

[n-3)] [Is any person not named on this enrollment form now pregnant by any person to be insured? ..... ☐ Yes ☐ No]

IF EITHER [N-2] OR [N-3] IS ANSWERED "YES," MEDICAL COVERAGE CANNOT BE ISSUED.

QUESTIONS N-4 – N-6 FOR FEMALE APPLICANTS:

[n-4)] [Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage? ..... ☐ Yes ☐ No]

[n-5)] [Date of Last Pap Smear: _____ Results: _____]

[n-6)] [Have you been instructed to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear? ..... ☐ Yes ☐ No]

[15.] [Been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession? ..... ☐ Yes ☐ No]

[16.] [Been diagnosed as having or been treated for any immune deficiency disorder by a member of the medical profession? ..... ☐ Yes ☐ No]

[17.] [Experienced any of the following: Signs and symptoms of an immune deficiency disorder may include lymphadenopathy (swollen lymph nodes); loss of appetite; weight loss; chronic fatigue; fever; oral thrush; skin rashes; unexplained infections; dementia; depression; or other psychoneurotic disorders with no known cause? ..... ☐ Yes ☐ No]

[18.] [Had surgery or has diagnostic testing, treatment or surgery been recommended or scheduled that has not been completed? ..... ☐ Yes ☐ No]

HEALTH STATEMENT *CONTINUED*

[19.] [Does any person have any fixation/prosthetic devices present including but not limited to: plates; screws; pins; implants (including breast implants); shunts; pacemakers or valve replacements? ..... ☐ Yes ☐ No]

[20.] [Had an electrocardiogram, chest x-ray, or blood test or any other diagnostic testing of any kind or been hospital confined in the past 10 years? ..... ☐ Yes ☐ No]

[If "Yes," give name of physician or hospital and results [on the Additional Medical Details page].

[21.] [Been a member of Alcoholics Anonymous or had any treatment, including but not limited to, counseling for alcoholism or alcohol abuse or been advised by a physician to discontinue or decrease alcohol consumption?..... ☐ Yes ☐ No]

[22.] [Used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs; or received treatment for drug abuse or chemical dependency?..... ☐ Yes ☐ No]

ADDITIONAL QUESTIONS

[23.] [To the best of your knowledge, does any person to be insured have any mental or physical impairment, disease or deformity not indicated above? ..... ☐ Yes ☐ No]

[24a.] [Have you or your spouse [/domestic partner] [/civil union] (if to be insured) smoked cigarettes or used tobacco in any form or nicotine substitute within the past year? PRIMARY INSURED..... ☐ Yes ☐ No]

[SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION] (if to be insured)..... ☐ Yes ☐ No]

[24b.] [Have you or your spouse [/domestic partner] [/civil union] EVER smoked cigarettes or used tobacco products? ..... ☐ Yes ☐ No]

[If "Yes," indicate who, amount per day and year quit [on the Additional Medical Details page].]

[25.] [Is any proposed insured currently taking, or taken within the past 12 months, any prescription medication[,] [or] receiving medical treatment of any kind [or is currently taking, or taken, any non-prescription medication on a daily basis]? ..... ☐ Yes ☐ No]

[If "Yes," provide details of treatment including name and dosage of all medications [on the Additional Medical Details page].]

REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE

[26.] [Has there been any medical treatment or medication use for, or have you consulted with a physician concerning the condition(s) which has had a Condition Specific Deductible, been ridered or rated since the covered person's effective date? ..... ☐ Yes ☐ No]

[If "Yes," provide details [on the Additional Medical Details page].]

OTHER PHYSICIANS

[27.] [Regular physician or medical practitioner for each proposed insured. If none, provide last physician seen, date, reason and results.

Primary Proposed Insured's Physician _____

Address _____

Date Last Seen_____ Reason & Results _____

Spouse's [/Domestic Partner's] [/Civil Union's] Physician _____

Address _____

Date Last Seen_____ Reason & Results _____

Child's Name_____ Physician _____

Address _____

Date Last Seen_____ Reason & Results _____

Child's Name_____ Physician _____

Address _____

Date Last Seen_____ Reason & Results _____

Child's Name_____ Physician _____

Address _____

Date Last Seen_____ Reason & Results _____]

ADDITIONAL MEDICAL DETAILS

Attach a separate sheet if additional space is needed. Date and sign any additional sheets.

	Provide Dates, Type of Treatment and Results	Name of Doctor/Hospital and Complete Address and Phone Number
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
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Person: **Condition:** **Question #:**		

HIPAA ELIGIBILITY

[Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the following statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

☐ **No, I or anyone to be insured do not meet one or more of the foregoing requirements.**

☐ **Yes, I or anyone to be insured meet all of the foregoing requirements.]**

AUTHORIZATION

[I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. The enrollment form and any amendments shall be the basis for the contract. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date we receive the enrollment form; B) the requested Effective Date. A change in the health of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company. The contract may only be effective prior to the contract delivery subject to the terms of the Conditional Receipt.]

[I agree that a photographic copy of this authorization shall be valid for two years from the date signed.]

[I acknowledge receiving the notification regarding the Medical Information Bureau, the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.]

[We, the undersigned Proposed Insured(s) and agent, acknowledge that the Proposed Insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.]

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

_____
Signature of Primary Proposed Insured

_____ _____ A.M. / P.M. _____ _____
Date Signed **Time Signed** **City** **State**

_____
Signature of Spouse[/Domestic Partner] [/Civil Union] or Other ***(if proposed to be insured)***

_____
Signature(s) of Other Dependent(s) 18 or Over ***(if proposed to be insured)***

_____
Guardian's Signature

Requested Effective Date: _____

Premium Amount Sent: $ _____

One-time Processing Fee Sent*: _____
**Not applicable in all states*

Conditional Receipt Taken: ☐ **Yes** ☐ **No**

Attention: (Agent)

I have reviewed this enrollment form to ensure that all required items have been completed.

To the best of knowledge, there ☐ **IS** ☐ **IS NOT** a replacement of medical insurance involved in this transaction.

Are you aware of any mental or physical impairment, disease, or deformity of any proposed insured which is not disclosed on the enrollment form? ☐ **Yes** ☐ **No**

If "Yes," please explain. _____

_____

_____
Licensed Resident Agent's Signature

_____
Print Agent's Name

_____ Initial here if you witnessed the signing of this form by the proposed insured.

ADDITIONAL NOTICES

[NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]
Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB], upon request, will supply such company with the information in its file.
Upon receipt of a request from you, [MIB] will arrange disclosure of any information it may have in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].
Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES
To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY
We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

CONDITIONAL RECEIPT

This Conditional Receipt is received from _____, this _____ day of

_____ *(month)* _____ *(year)*.

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which Time Insurance Company receives the application at its home office.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned.

If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company receives the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.

Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

AGENT/AGENCY INFORMATION

Agent Name: _____ Phone Number: _____

Agent Number: _____ E-mail Address: _____

Key Agency Contact: _____ Agency Name: _____

Fax Number: _____ Agency Number: _____

[Policy should be mailed to:] [☐ Agent] [☐ Agency] [☐ Policyholder]

TYPE OF ACTIVITY *(Please check appropriate box.)*

[☐ **NEW**] [*If not a new enrollee, check appropriate box and list affected policy number.]*

[☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** _____]

[☐ Internal Replacement]
[☐ Adding Dependent]
[☐ Removal of Tobacco Rates]
[☐ Applying for Preferred Rates]
[☐ Removal of Condition Specific Deductible or Special Exception Rider]
[☐ Removal/Reduction of Special Class Premium]
[☐ Conversion (over age dependent/divorce)]
[☐ Policy/Benefit Change to an Existing Policy]
[*List Type Of Change Requested:* _____]
[☐ Reinstatement of Coverage]

PERSON(S) TO BE INSURED

	Name *Last* *First* *MI*	Sex	Age	Birthdate *(MM/DD/YY)*	State of Birth	Social Security Number
1. PRIMARY						
2. SPOUSE[/ DOMESTIC PARTNER] [/CIVIL UNION]						

3. DEPENDENT(S) ***(list relationship)***	Name *Last* *First* *MI*	Sex	Age	Birthdate *(MM/DD/YY)*	Full-time Student?	Social Security Number

4. Resident Address: _____
(NO P.O. BOXES) *(Street)* *(City)* *(State)* *(ZIP)*

5. Phone Number: (_____) _____ 6. E-mail Address: _____

7a. Are any of the proposed insureds covered by any type of medical insurance? . . . . . ☐ Yes (Complete section below)

. . . . . ☐ No (Go to BILLING)

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date *(MM/DD/YY)*	Termination Date *(MM/DD/YY)*	Is this coverage being replaced by proposed coverage?

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

7b. [Primary Insured Occupation: _____
Company Name: _____ Work Number: (_____) _____
Duties: _____]
[Is the Primary insured [self-employed] [or] [a sole proprietor]? . . . . . ☐ Yes ☐ No]
[Is the Primary Insured covered by Workers' Compensation?. . . . . ☐ Yes ☐ No]

7c. [Spouse [/Domestic Partner] [/Civil Union] Occupation: _____
Company Name: _____ Work Number: (_____) _____
Duties: _____]
[Is the Spouse[/ Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]? . . . . . ☐ Yes ☐ No]
[Is the Spouse[/ Domestic Partner] [/Civil Union] covered by Workers' Compensation?? . . . . . ☐ Yes ☐ No]

[BILLING

[☐ Monthly Check-O-Matic] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual] [☐ List Bill *(monthly only)*]

[Credit Card:] [☐ First Payment Only*] [☐ Monthly] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual]

*[*With this option, you must select a secondary billing mode for subsequent payments. Please make selection above and provide all necessary information.]*

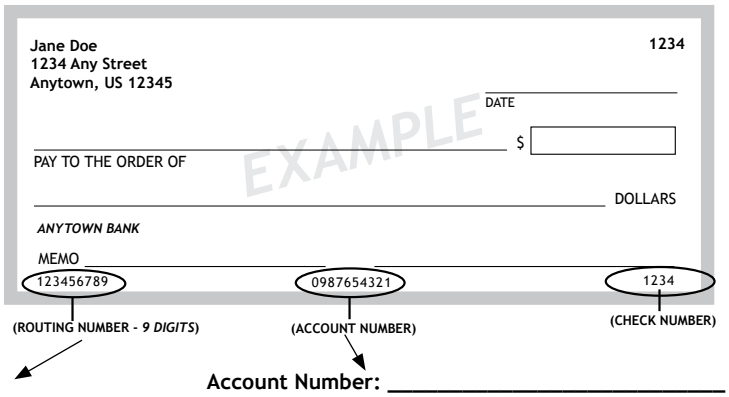
If billing address is different than resident address, please complete:

Payor Name | Address | City | State | ZIP

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY – *Choose the following option that applies:*

☐ **To begin Check-O-Matic withdrawals:**
Select a desired withdrawal day (1–28): _____
Bank Name: _____
City: _____ State: _____

☐ **To add this policy to an existing Check-O-Matic:**
Existing COM Number: _____
Associated Policy Number: _____



Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

☐ **Check-O-Matic** *(Complete authorization below)*

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signature of Payor | Date Signed

[AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

☐ VISA Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ MasterCard Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Exp. Date: _____ / _____ [Security Code Number (3 digits on back of credit card): ___ ___ ___]

Name as it appears on card: _____

Signature of Payor: _____ Date: _____]]

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

[COMPLETE IF REQUESTING LIFE INSURANCE COVERAGE

Beneficiary for Primary Insured: _____

(Full Name) *(Relationship)*

Contingent Beneficiary: _____

(Full Name) *(Relationship)*

The Primary Insured is the beneficiary of any Spouse [/Domestic Partner] [/Civil Union] or Child(ren) Life Insurance.]

[HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION

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I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

_____]

Member Signature Date

[HIPAA ELIGIBILITY

[Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the following statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

☐ **No, I or anyone to be insured do not meet one or more of the foregoing requirements.**

☐ **Yes, I or anyone to be insured meet all of the foregoing requirements.]**

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are personally paying the entire premium for this health Insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? . . . . . ☐ Yes ☐ No

AUTHORIZATION

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) I must call Time Insurance Company and complete the Personal Health History portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto. (2) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Time Insurance Company. (3) Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (4) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (5) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

Signature of Primary Proposed Insured

Signature of Spouse or Other Insured (if proposed to be insured)

(Circle one)
A.M. / P.M.

Date Signed | Time Signed | City & State | Requested Policy Effective Date

Conditional Receipt Given? ❑ Yes ❑ No

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

ADDITIONAL NOTICES

[NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]
Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB], upon request, will supply such company with the information in its file.
Upon receipt of a request from you, [MIB] will arrange disclosure of any information it may have in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].
Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES
To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY
We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]

CONDITIONAL RECEIPT

This Conditional Receipt is received from _____, this_____ day of _____ *(month)*

_____*(year)*.

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which the Personal Health History call is completed.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned. If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date on which the Personal Health History call is completed. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.]

LEAVE THIS PAGE WITH THE CUSTOMER – DO NOT FAX

ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

January 29, 2010

Arkansas Department of Insurance
1200 W. Third Street
Arkansas Department of Insurance

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Enrollment Form for Medical Insurance for Individuals and Families: 29300 (Rev. 1/2010)
Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and Families: 29400 (Rev. 1/2010)
Tele-App Part 2 Enrollment Form for Medical Insurance for Individuals and Families: 29500 (Rev. 1/2010)
Preferred Rating Questionnaire: 26566
Amendment of Enrollment form: 30216

Dear Sir or Madam:

The above-referenced forms are submitted for your review and approval: Enrollment Form for Medical Insurance for Individuals and Families, 29300 (Rev. 1/2010), 29400 (Rev. 1/2010) and 29500 (Rev. 1/2010).

Form number 29300 is completed when an applicant is applying for coverage through the paper application process. The form series 29400 and 29500 are completed when an applicant is applying for coverage through the telephone application process, an online process or software based process.

Also enclosed are a Preferred Rating Questionnaire and an Amendment to the enrollment form. The amendment is used when the consumer wants to amend their response to a question on a previously completed application.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Upon approval, the amended forms will be used to market major medical insurance to individuals by independent agents licensed in your state.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Christine R. Fleming
Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168

Policy #: _____

Acceptance of Offer and Attestation

I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. My recorded Personal Health History, the enrollment form and any amendments shall be the basis for the offer of coverage. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. I shall sign the enrollment form and obtain the signatures of my [Spouse] [Domestic Partner] [Civil Union] and any covered dependents over the age of 18, and return it to Time Insurance Company within 30 days of the contract issue. If acceptance is not received within 30 days, Time Insurance Company reserves the right to revoke any and all such offers. The first full premium must be paid. The contract may only be effective prior to the contract delivery and acceptance, if all the terms of the Conditional Receipt have been fulfilled.

I agree that a photocopy of this authorization shall be valid for two years from the date signed. I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding the Medical Information Bureau, the Privacy statement concerning my personal health information, the Abbreviated Notice of Insurance Information Practices, and the Outline of Coverage for Health Insurance, if required.

We, the undersigned proposed insured(s) and agent acknowledge that the proposed insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

_____

Signature of Proposed Insured

_____ _____

Date Signed State

_____

Signature of Spouse or Other Insured

_____

Signature(s) of Other Dependents 18 or Over

_____

Guardian's Signature

If Life Insurance is issued, complete this section.

Beneficiary for Primary Insured:

_____

Full Name and Relationship

Contingent Beneficiary:

_____

Full Name and Relationship

(The Primary Insured is the Beneficiary of any spouse [/domestic partner] [/civil union] or child(ren) life insurance.)

Assurant Health 501 West Michigan Milwaukee, WI 53203 [Fax 414-299-6020]
Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENCY INFORMATION

Agent Name: _____ Phone Number: _____

Agent Number: _____ E-mail Address: _____

Key Agency Contact: _____ Agency Name: _____

Fax Number: _____ Agency Number: _____

[Policy should be mailed to:] [☐ Agent] [☐ Agency] [☐ Policyholder]

TYPE OF ACTIVITY *(Please check appropriate box.)*

[☐ **NEW**] [*If not a new enrollee, check appropriate box and list affected policy number.]*

[☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** _____]

[☐ Internal Replacement]
[☐ Adding Dependent]
[☐ Removal of Tobacco Rates]
[☐ Applying for Preferred Rates]
[☐ Removal of Condition Specific Deductible or Special Exception Rider]
[☐ Removal/Reduction of Special Class Premium]
[☐ Conversion (over age dependent/divorce)]
[☐ Policy/Benefit Change to an Existing Policy]
[*List Type Of Change Requested:* _____]
[☐ Reinstatement of Coverage]

PERSON(S) TO BE INSURED

	Name *Last*	*First*	*M.I.*	Sex	Age	Birthdate *MM/DD/YY*	State of Birth	Height	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S)	**Name** *Last*	*First*	*M.I.*	**Sex**	**Age**	**Birthdate** *MM/DD/YY*	**Full-Time Student?**	**Height**	**Weight**	**Social Security Number**

4a. Resident Address: _____
(Street) (City) (State) (ZIP)

4b. E-mail Address: _____

[5.] [Does any proposed insured live outside the above household? . . . . . ☐ Yes ☐ No]

If "Yes," explain. _____

[6.] Phone Number: (_____) _____ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. (_____)_____**]**

[7a.] **Primary Insured** Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Primary Insured [self-employed] [or] [a sole proprietor]? . . . . . ☐ Yes ☐ No

Is the Primary Insured covered by Workers' Compensation? . . . . . ☐ Yes ☐ No

[7b.] **Spouse[/Domestic Partner] [/Civil Union]** Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Spouse[/Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]? . . . . . ☐ Yes ☐ No

Is the Spouse[/Domestic Partner] [/Civil Union] covered by Workers' Compensation? . . . . . ☐ Yes ☐ No

[OTHER COVERAGE IN FORCE OR APPLIED FOR

[8.] [Are any of the proposed insureds covered by, or has application been made for any type of medical insurance? . . . . . ☐ Yes ☐ No]

[If "Yes," complete the section below.

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date *(MM/DD/YY)*	Termination Date *(MM/DD/YY)*	Is this coverage being replaced by proposed coverage?

]

[9.] [Were all proposed insureds covered under the prior plan listed above? . . . . . ☐ Yes ☐ No]

[If "No," list those not covered. _____]

[10.] [Have any of the proposed insureds [within the last [10] years] been declined, postponed, rescinded, reformed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance? . . . . . ☐ Yes ☐ No]

[If "Yes," give details. _____

_____]]

HAZARDOUS ACTIVITIES AND DRIVING

[11.] [In the last [10] years, have any of the proposed insureds participated in any motorized vehicle racing (includes drivers, pit crew, owners or mechanics) or any of the following activities: skydiving, ultralight flying, scuba diving, hang gliding, rock or mountain climbing or rodeo participation? . . . . . ☐ Yes ☐ No]

[12.] [In the last [10] years, have any of the proposed insureds been cited for operating a motor vehicle under the influence of alcohol or drugs? . . . . . ☐ Yes ☐ No]

BILLING

[☐ Monthly Check-O-Matic] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual] [☐ List Bill *(monthly only)*]

[**Credit Card:**] [☐ First Payment Only*] [☐ Monthly] [☐ Quarterly] [☐ Semi-Annual] [☐ Annual]

*[*With this option, you must select a secondary billing mode for subsequent payments. Please make selection above and provide all necessary information.]*

If billing address is different than resident address, please complete:

Payor Name _____ Address _____ City _____ State _____ ZIP _____

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY - *Choose the following option that applies:*

☐ **To begin Check-O-Matic withdrawals:**

Select a desired withdrawal day (1-28): _____

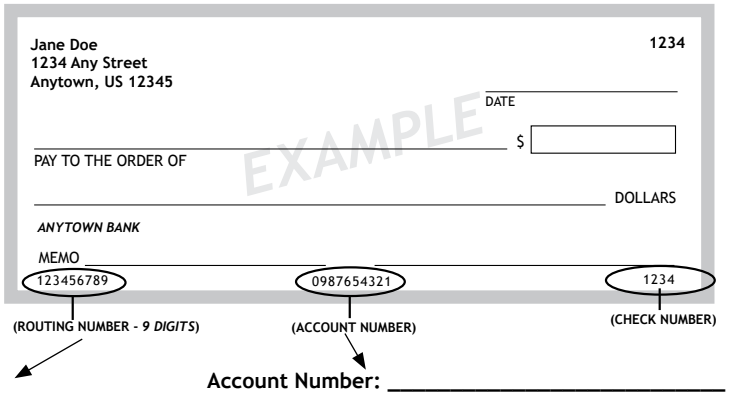
Bank Name: _____

City: _____ State: _____

☐ **To add this policy to an existing Check-O-Matic:**

Existing COM Number: _____

Associated Policy Number: _____



Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

☐ **Check-O-Matic** *(Complete authorization below)*

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signature of Payor _____ Date Signed _____

[AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

☐ VISA Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ MasterCard Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Exp. Date: _____ / _____ [Security Code Number (3 digits on back of credit card): ___ ___ ___]

Name as it appears on card: _____

Signature of Payor: _____ Date: _____]

HEALTH STATEMENT

For Questions 13-25, WITHIN THE LAST [10] YEARS, HAS ANY PROPOSED INSURED:

[Note: any follow-up visits in the last [10] years as a result of a diagnosis over [10] years ago must be disclosed.]

[13.] [Had surgery [in a hospital or outpatient facility]? ..... ☐ Yes ☐ No]

[14.] [Had medical treatment [in a hospital or outpatient facility] [other than already disclosed]? ..... ☐ Yes ☐ No]

[15.] [Had any urgent care or emergency room visits [not disclosed in Questions [13] & [14]]? ..... ☐ Yes ☐ No]

[16.] [Received treatment, testing, consulted with or received a diagnosis from a physician or healthcare provider [other than already disclosed]? [Do NOT include annual physical exams.] ..... ☐ Yes ☐ No]

[17.] [Had any testing [with abnormal findings] or tests for which you have not received results [other than already disclosed]? ..... ☐ Yes ☐ No]

[18.] [Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed? ..... ☐ Yes ☐ No]

[19.] [Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups? ..... ☐ Yes ☐ No]

[20.] [Used illegal drugs or prescription medication other than as prescribed or been advised by a physician or health care provider to discontinue or decrease alcohol consumption or drug use? ..... ☐ Yes ☐ No]

Additional Questions

[21.] [Has any proposed insured taken or been advised to take any prescription medication in the last [[10] years] [[12] months]? ..... ☐ Yes ☐ No]

[22.] [Has any proposed adult [ever] used tobacco products in any form or nicotine substitutes [within the last [10] years] [after the age of [21]]? ..... ☐ Yes ☐ No]

[23.] [Has any proposed insured had a diagnosis, [[or] treatment] [or follow-up] for cancer in the last [10] years? ..... ☐ Yes ☐ No]

[24.] [Is any proposed insured currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy? [This includes a surrogate mother or any person that she is contracted with.] ..... ☐ Yes ☐ No]

[25.] [Have you fully disclosed all medical conditions for you and your family within the last [10] years? ... ☐ Yes ☐ No]

[## REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE

[26.] [Has there been any medical treatment or medication use for, or have you consulted with a physician or healthcare provider concerning the condition(s) which has had a Condition Specific Deductible, been ridered or rated since the covered person's effective date? ..... ☐ Yes ☐ No]]

[
OTHER PHYSICIANS

[Physician or Healthcare Provider seen in the last [10] years for each proposed insured [other than disclosed above]?

Person ______________________ Physician ______________________ Specialty ______________________
Address or Phone Number ____
Date Last Seen ________ Reason & Results ______________________ Follow-up visit: ☐ Yes ☐ No Date ______

Person ______________________ Physician ______________________ Specialty ______________________
Address or Phone Number ____
Date Last Seen ________ Reason & Results ______________________ Follow-up visit: ☐ Yes ☐ No Date ______

Person ______________________ Physician ______________________ Specialty ______________________
Address or Phone Number ____
Date Last Seen ________ Reason & Results ______________________ Follow-up visit: ☐ Yes ☐ No Date ______

Person ______________________ Physician ______________________ Specialty ______________________
Address or Phone Number ____
Date Last Seen ________ Reason & Results ______________________ Follow-up visit: ☐ Yes ☐ No Date ______

Person ______________________ Physician ______________________ Specialty ______________________
Address or Phone Number ____
Date Last Seen ________ Reason & Results ______________________ Follow-up visit: ☐ Yes ☐ No Date ______]]

[
ADDITIONAL MEDICAL DETAILS

Attach a separate sheet if additional space is needed. Date and sign any additional sheets.

	Provide Dates, Type of Treatment and Results	**Name of Physician or Healthcare Provider, and Complete Address and Phone Number**
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		

]

ADDITIONAL NOTICES

[NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB], upon request, will supply such company with the information in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information it may have in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

ADDITIONAL NOTES

[HIPAA ELIGIBILITY

[Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the following statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

☐ **No, I or anyone to be insured do not meet one or more of the foregoing requirements.**
☐ **Yes, I or anyone to be insured meet all of the foregoing requirements.]**]

[EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly. Do you agree with this statement? . . . . . ☐ Yes ☐ No]

[AUTHORIZATION

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) I must call Time Insurance Company and complete the Personal Health History portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto. (2) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Time Insurance Company. (3) Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (4) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (5) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

_____	_____	_____ A.M./P.M.	_____	_____
Signature of Primary Proposed Insured	**Date Signed**	**Time Signed**	**City**	**State**

Signature of Spouse[/Domestic Partner] [/Civil Union] or Other *(if proposed to be insured)*

Signature(s) of Other Dependent(s) 18 or Over *(if proposed to be insured)*

Guardian's Signature

Requested Effective Date: _____ **Premium Amount Sent: $** _____ **One-time Processing Fee Sent*:** _____]

**Not applicable in all states*

ASSURANT Health®

Preferred Rating Questionnaire

Complete this questionnaire to determine eligibility for the **[Preferred]** or **[Preferred Smoker]** rating classes.

_____

Primary Proposed Insured's Name (please print)

[*Note: A proposed insured *may* be eligible for a Preferred Smoker rating if he or she is able to truthfully answer questions [2,] [3] [and] [4] "No." Underwriting reserves the right to apply tobacco ratings based upon lab results, phone verification or medical records.]

Each proposed insured must complete and sign the appropriate sections. Spouses[/Other Insured] are considered separately for preferred rating eligibility and must also answer this questionnaire. This information is not required for dependents.

	PRIMARY	**SPOUSE [/OTHER INSURED]**
[1.] [Has the proposed insured used tobacco products at any time during the past [3] years? (If NO, go to question [5.])	☐ Yes ☐ No	☐ Yes ☐ No]
[2.] [Did the proposed insured previously smoke or do they currently smoke [10] or more cigarettes per day?	☐ Yes ☐ No	☐ Yes ☐ No]
[3.] [Did the proposed insured previously smoke or do they currently smoke more than [1] cigar or pipe per day?	☐ Yes ☐ No	☐ Yes ☐ No]
[4.] [Did the proposed insured previously use or do they currently use chewing tobacco?	☐ Yes ☐ No	☐ Yes ☐ No]
[5.] [Is the proposed insured currently outside the weight range listed in the build chart?	☐ Yes ☐ No	☐ Yes ☐ No]
[6.] [Has the proposed insured had blood pressure readings in excess of [140]/[90] or been treated for elevated blood pressure in the past [12] months?	☐ Yes ☐ No	☐ Yes ☐ No]
[7.] [Has the proposed insured had cholesterol readings above [220] or a cholesterol/HDL ratio above [3.5] or been treated for elevated cholesterol or triglycerides within the past [12] months?	☐ Yes ☐ No	☐ Yes ☐ No]
[8.] [Has the proposed insured had any citations for DUI or more than [1] moving violation including speeding ticket(s) within the past [2] years?	☐ Yes ☐ No	☐ Yes ☐ No]
[9.] [Has the proposed insured had a complete physical exam within the past [3] years?**	☐ Yes ☐ No	☐ Yes ☐ No]

*** Individuals age [40] and over must have had a physical exam in the past [3] years to qualify for preferred rates.*

_____ _____

Primary Proposed Insured Signature *Date* *Spouse or Other Insured Signature* *Date*

_____ _____

[Driver's License Number] *[Driver's License Number]*

_____ _____

Licensed Agent Signature *Date* *Agent Number*

ASSURANT Health®

Time Insurance Company
501 W. Michigan Street
[P.O. Box 624]
Milwaukee, WI 53201-0624
[800-800-1212]

AMENDMENT OF APPLICATION/ENROLLMENT FORM

I, [John Doe], hereby amend my application/enrollment form to Time Insurance Company dated [December 03, 2009] as follows:

[Insert Amendment Verbiage Here.]

*****PLEASE READ AND COMPLETE THE FOLLOWING:*****

I hereby represent that the above statements are true and complete to the best of my knowledge and belief. I agree that this form shall be an amendment to the original application/enrollment form and of any [policy]/[certificate] issued hereunder. I also agree that no coverage shall be in effect until this form shall have been completed and the full premium paid.

Accepted at:

_____ _____

City or Town, State. Date.

Signature of Insured (listed above): **X** _____

[John Doe]
(If minor, legal guardian signature needed)

[Signature of Owner/Primary Insured:] **X** [_____]

[(If minor, legal guardian signature needed)]

[Agent's Signature:] **X** [_____]

Policy/Certificate No. [000012345]

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